



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM  
C/O DAVIS FULLER JACKSON KEENE  
11044 RESEARCH BLVD STE A-425  
AUSTIN TX 78759

#### **Respondent Name**

TPCIGA FOR CREDIT GENERAL INDEMNITY CO

#### **Carrier's Austin Representative Box**

Box Number 50

#### **MFDR Tracking Number**

M4-98-B966-01

#### **MFDR Date Received**

MAY 20, 1998

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "To avoid litigation, which my client would prefer to do, you are requested to pay my client's actual damages in the amount of \$14,038.90, together with reasonable attorney's fees as of this writing in the amount of \$750.00, through my office within sixty (60) days of your receipt of this letter."

**Amount in Dispute:** \$14,038.90

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** A response was received from the respondent on August 13, 1998.

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 1997 to June 3, 1997	Inpatient Hospital Services	\$14,038.90	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following payment exception codes:
  - N – No supporting medical documentation received.

## **Findings**

1. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
2. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
3. Review of the submitted documentation finds that:
  - The requestor's position statement asserts that "To avoid litigation, which my client would prefer to do, you are requested to pay my client's actual damages in the amount of \$14,038.90, together with reasonable attorney's fees as of this writing in the amount of \$750.00, through my office within sixty (60) days of your receipt of this letter."
  - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
  - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
4. The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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03/25/2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**